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ABSTRACT

Identity formation involves the development of self esteem, social skills, and a sense of self. Many gay and lesbian adults have noted that they were aware of their attraction to members of the same sex as early as five- and six-years-old. Reactions they received from parents and others often added to their stress. Following a description of the Diagnostic Statistical Manual of Mental Disorders IV diagnosis of Gender Identity Disorder, this paper offers helping professionals information on counseling families and adults about Gender Identity Disorder. Therapeutic strategies used for treating children can include family therapy, psychotherapy, parental counseling, and behavior therapy. Being a caring and nonjudgmental helping professional can aid in building a support system for the child or adolescent, which is desperately needed during the time they are trying to figure out who they are. Sensitivity and awareness are the two greatest assets the counselor can have when working with these clients. (JDM)

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Gender Identity Disorder in Children

Many gay and lesbian adults have noted that they were aware of their attraction to members of the same sex as early as five and six years old (Cantwell, 1996). Parents who seek professional help for their child usually concluded that their child's extensive cross gender behavior was a concern and should be limited or eliminated (Rottneck, 1999). Green and Blanchard (2000) pointed out that some parents' ultimate counseling goal for their pre-homosexual or pre-transsexual child was to prevent the child from becoming homosexual. Parents became concerned with the ostracism that took place in the schools and other social settings. The negative reactions from others on the child's specific cross gender activity and behavior can cause added stress to their everyday functioning. Cooley (1998) noted that identity formation includes development of self-esteem, social skills and a sense of identity. These things can be especially hard while growing up when one realizes he or she may be different from his or her friends. This paper will give background information on the DSM-IV diagnosis Gender Identity Disorder (GID). For those helping professionals (e.g., counselors, school administrators, nurses, and other Para-professionals) this paper will discuss: 1.) Diagnosis, 2.) Caregivers assessment of particular behaviors, 3.) Treatment, 4.) Secondary treatment issues and, 5.) Counseling Implications.

Diagnosis of Gender Identity Disorder

The category of gender identity disorder did not appear in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until its third edition in 1980 (Zucker & Bradley, 1995). The DSM-IV-TR contains two major descriptive criteria, one differential criterion, and one severity criterion for a diagnosis of GID in children. Criterion A refers to a child's identification with the opposite gender (Zucker & Bradley, 1995). A child must exhibit at least four of the five

behavioral characteristics in Criterion A. These are: (1) a repeatedly stated desire to be, or insistence that he or she is the other sex; (2) in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing; (3) strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex; (4) intense desire to participate in the stereotypical games and pastimes of the other sex; and (5) strong preference for playmates of the other sex (DSM-IV-TR). Criterion B refers to a child's rejection of his or her own anatomic status, same-sex stereotypical activities or both (Zucker & Bradley, 1995). A child may exhibit any of the behavioral stereotypic attributes of Criterion B, which includes a persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In children, the disturbance is manifested by any or all of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games and activities: in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing (DSM-IV-TR). Criterion C is the differential criterion, which states that the disturbance is not concurrent with a physical intersex condition. (DSM-IV-TR). Criterion D is the severity criterion, which states that the disturbance is severe and causes clinically significant distress or impairment in important areas of functioning such as social, interpersonal, or occupational (DSM-IV-TR)."

There are four subtypes of GID. The categories differentiate by sexual attraction (Kaplan & Sadock's, 2000). The four categories are: (a.) sexually attracted to males, (b.) sexually attracted to females, (c.) sexually attracted to both, or (d.) sexually attracted to neither (Kaplan & Sadock's, 2000).

Several situations occur which may resemble GID on the surface, yet there are characteristics that differentiate them from a true diagnosis of GID. One of these situations is a sudden onset of the symptoms of GID, which on closer inspection are often revealed to be the result of feelings of displacement or jealousy (Zucker & Bradley, 1995). A typical example is the birth of a sibling of the opposite sex. These symptoms most often remit over time without intervention. A second situation is a type of cross dressing that involves use of undergarments that function in self soothing or reduction of anxiety (Zucker & Bradley, 1995). In gender identity disorder, the cross dressing involves outer garments that serve to make the child appear to be of the opposite sex.

Caregivers Assessments

Mothers and fathers awareness of gender identity disorder differs in many ways. Cantwell (1996) noted that fathers were told, but mothers observed or made connections. Mothers were able to see their child's opposite-sex gender behavior more than fathers. Parents tend to be receptive to the feelings of their child, however there are times when these feelings are either misunderstood or not acknowledged by parents. This lack of understanding is a result of how society looks at children when they do not conform to traditional gender behaviors. It is obvious that boys bear the brunt of negative comments when it comes to their mannerisms. Yet, girls are not ridiculed as much for their tomboyish mannerisms. Green and Blanchard (2000) noted that GID has fewer such outcomes for women, possibly because of society's greater tolerance of cross-gender behavior in girls and women.

Parents are very aware of specific behaviors from their children. Several parents described effeminate behaviors about their male child such as: avoiding rough-and-tumble play and competitive sports, drawing pictures of beautiful girls and princesses, preferring girls as

playmates, assuming a "mother role" when playing house, playing with female type dolls and dressing up in women's/girls clothing (Rottneck, 1999). Parents also described the following behaviors about their female child: lack of interest in dolls, preference for boys clothing, intense negative reactions to parental expectations to wear feminine attire, preference for boys as playmates with whom rough-and-tumble play is shared and identification with powerful male figures takes place (Rottneck, 1999).

It is not surprising that parents when they first witness and hear their child make statements or act the opposite of their own sex dismiss the acts with phrases such as "it's just a phase" or " they'll grow out of it." When parents were asked the question, "At what age in the life of your child did you begin to think or feel that he or she might be other than heterosexually oriented?" Their answers from both mothers and fathers of gay or lesbian adults on the average were from ages 17-22 years old. However, gay males and lesbian females, answered on the average with age 5-6 years old (Cantwell 1996, p. 47). In a study of 29 gay and bisexual male teenagers ages 15-19, 31% recalled an attraction to men by age six (The Center for Population Options Fact Sheet, 1992). Parents often report the onset of cross-gender behavior before the age of three (Kaplan & Sadock's, 2000). While most parents may worry about the behaviors of their child, it is important to recognize the fact that confusion about sexual identity is not uncommon in any adolescent. One must be clear that behavior and identity differ from one another. As stated by Ryan (1998) sexual activity is a behavior, whereas sexual orientation is a component of identity. Caregivers should be aware that ones first awareness of homosexual attraction, first homosexual experience and self-identification as gay or lesbian are all separate categories that take place at different ages (Ryan, 1998).

Treatment

Treatment of GID in children has been very controversial over the years in terms of ethical issues, legal issues and clinical approaches. Rottneck (1999) indicates the treatment of GID in children has specific goals to alleviate social ostracism as a short-term goal and to prevent adulthood homosexuality or transexuality. This type of treatment takes the position of changing ones sexual orientation. Criticism came about when psychologist, George Rekers, focused his treatment on reinforcing masculine behaviors and extinguishing feminine behaviors for boys with GID (Rottneck, 1999). He later clarified his treatment goals was to widen the child's repertoire of behavior not to change it.

Several types of therapeutic strategies are used for treating children with GID such as Eclectic combinations of therapies, group counseling, family therapy, psychotherapy parental counseling and behavior therapy (Rottneck, 1999). Several therapists have used behavior therapy. Behavior therapy focuses on unlearning certain behaviors as one of the objectives. It can also entail the use of a reward system for positive behavior and punishment for negative behaviors. In the treatment of GID, therapists have rewarded children for behaving appropriately as it relates to their individual sex. Punishments were given for a boy that displayed overt "girlish" mannerisms and "tomboyish" conduct in girls. Parental counseling involves limit setting. Rottneck (1999) states parental counseling involves: disallowing cross gender role play, restricting playing with cross sex toys, encouraging same sex-appropriate activities and helping children engage in same sex peer relations. If a parent took a neutral stance of ignoring the behaviors, this could be taken as positive and the child would continue the cross gender behaviors. Consistency with parental action is very important during the counseling process.

Homophobic biases can easily interfere with the counseling process by a counselor or a parent. Kaplan and Sadock's (2000) discusses how clinically referred children by their parents are motivated by fears of transexuality or homosexuality. Several questions arise when treating children with GID; 1.) Is treatment an attempt to alter sexual orientation or behaviors in order to have the child adhere to societal norms? or 2.) Is treatment being done to provide the child and or family with coping skills and social support? The goals of counseling with parents should be set early. A child who is at risk for societal rejection will need to know how to cope with emotional stressors that may come about. Coping entails the building of strong self-esteem and a positive sense of self. This should be done by parents and helping professionals in a non-judgemental way. Rottneck (1999) clearly states that there is no evidence that treatment of GID in children has any impact on the child's later sexual or gender identity. However, it is important that helping professionals be supportive in answering questions concerning a child's sexual identity. It is during this time that there is a greater need for support, guidance, health education and referrals to avoid feelings of isolation experienced by these youth (Ryan, 1998).

Gender Identity Disorder is a disorder that is not without controversy. Several critics look at GID as a childhood manifestation of homosexuality. The argument against this is that there is not a 100 % concordance between GID and homosexuality. Since homosexuality is not a mental disorder, GID should not be considered a mental disorder. Some groups support the idea of "Reparative Therapy", which attempts to change a child to act more sex stereotypical, and thus prevent them from becoming homosexual. Those that use this type of intervention (also known as conversion therapy) still consider homosexuality as a mental disorder. These therapies have been shown to be unsuccessful, and can often be harmful to children (Just the Facts Coalition, 1999). A child should be given accurate information pertaining to the myths and

stereotypes about homosexuality and homophobia. Treatment that is done to alter sexual orientation is still considered to be difficult to evaluate and controversial. Kaplan and Sadock's (2000) note, whereas short-term behavioral changes toward more conventional gender-typed activities are described, few data are available about adult sexuality. The effects of psychiatric or psychological intervention with children with GID still need research to indicate whether sexual orientation in the future is affected.

Secondary Treatment Issues

Aside from issues directly related to a diagnosis of GID, children often have other conditions that require clinical attention. More often than not, other issues are prevalent such as depression, relationship problems, anxiety disorder or learning deficits (ADHD) upon the onset of counseling. As children grow older, they develop stronger patterns of segregation of their peer groups by sex. Children with GID, who prefer to interact with children of the opposite sex, do not identify with children of the same sex and are rejected by children of the opposite sex (Zucker & Bradley, 1996). This isolation and rejection by peers can lead to a number of problems for children. Depression, isolation, suicidal ideation, and somatoform disorders can be associated with emotional conflict and stress (Ryan & Futterman, 1998). Homosexuality is the most common post pubertal psychosexual outcome of gender identity disorder (Zucker & Bradley, 1996); therefore, it would be prudent to include associated mental health concerns of homosexuals in any discussion of GID. Stress from physical and verbal harassment from peers, but also adults, teachers, and even family members are commonly reported in homosexual adolescents. This type of treatment towards homosexuals has been associated with many negative outcomes, including school related problems, running away from home, conflict with the law, substance abuse, drug and alcohol abuse, prostitution, and suicide (Ryan & Futterman,

1998). Although many of these behaviors do not occur until later childhood or adolescence, children with GID should be monitored for these potential behaviors. Children with gender identity disorder have social limitations in family, social, or school settings. These limitations socially stigmatize and can cause he or she to feel dispirited.

Counseling Implications

As a counselor, one must be aware that children can show a variety of cross-gender behaviors as early as three years of age. Kaplan and Sadock's (2000) note that while there is no psychological test geared towards diagnosing a child with GID, two tests can be used to discriminate boys with gender identity disorder from gender-typical boys. When working with the family and child, the counselor needs to make the child feel comfortable with being in session. The It-Scale and The Draw-A-Person Test are considered to be good techniques to use (Kaplan & Sadock's, 2000).

It is important that if a counselor is not comfortable in discussing sexual orientation or cross-gender behaviors that a referral be made. The caliber of care a child receives depends on the comfort level of the helping professional. For helping professionals working with gender identity disorder in children, it is important for the professional to be aware of their own homophobic attitudes and biases. If one does not have insight into their own feelings before hand, they could project their feelings in a counseling session without being aware. A child needs a safe area where they can openly explore sexual orientation without judgmental comments or ridicule. One must be careful with language while talking to someone who may be experiencing sexual identity confusion. Heterosexist comments should be avoided. Being a caring and non-judgmental helping professional can aid in building a support system that adolescents and children so desperately need during times when society depicts homosexuality as

being negative. This type of support can help the child to clarify the identity confusion he or she may be feeling or acting out. In order to provide an accepting environment that is not only comfortable but also supportive, a counselor needs to become familiar with sexual identity development. Several models exist that describe the development of the coming out process (ie., Authors: Cass, Richard Troiden). No special type of training is needed in order to work with children or adolescents with gender identity disorder. Rather sensitivity and awareness is most important.

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